5-2-2018

Accumulating Stress Over the Life Course: Exploring Narratives of, Upward Mobility, Infant Mortality and Resiliency of African American Women with Higher SES

Trinadi Payton

ACCUMULATING STRESS OVER THE LIFE COURSE: EXPLORING NARRATIVES OF INFANT MORTALITY, UPWARD MOBILITY AND RESILIENCY OF AFRICAN AMERICAN WOMEN WITH HIGHER SES

by

TRINADI PAYTON

Under the Direction of Jamae Morris, PhD

ABSTRACT

Using semi-structured qualitative interviews, this study will examine the ways in which early childhood and adolescent experiences may provide insight into high effort coping styles, in the process of either grieving the loss of an infant or pregnancy due to miscarriage or stillbirth. The Sojourner Syndrome theory will be used to provide a lens towards understanding the dynamic ways that African American women, particularly those who have experienced child loss, confront adversities, helping to shed light on how they encounter and cope with related stress. This theory will allow for an expansion on the understandings of high effort methods of coping with stress among African American women with a special focus on resilience and resistance. A total of 4 African American women between 25-45 years of age who have experienced the loss of pregnancy due to miscarriage or stillbirth and who reside in the greater Atlanta area will be interviewed.

INDEX WORDS: Infant mortality, Race based stress, African American infant mortality, Sojourner Syndrome

ACCUMULATING STRESS OVER THE LIFE COURSE: EXPLORING NARRATIVES OF INFANT MORTALITY, UPWARD MOBILITY AND RESILIENCY OF AFRICAN AMERICAN WOMEN WITH HIGHER SES

by

TRINADI PAYTON

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Masters of Arts

in the College of Arts and Sciences

Georgia State University

2017

ACCUMULATING STRESS OVER THE LIFE COURSE: EXPLORING NARRATIVES OF INFANT MORTALITY, UPWARD MOBILITY AND RESILIENCY OF AFRICAN AMERICAN WOMEN WITH HIGHER SES

by

TRINADI PAYTON

Committee Chair: Jamae Morris

Committee: Kimberly Farris

Sarita Davis

Electronic Version Approved:

Office of Graduate Studies

College of Arts and Sciences

Georgia State University

May 2018

DEDICATION

This study is first dedicated to Hilary Blessing Warren who was born and laid to rest on August 20, 2012. at 37 weeks gestation and after 3 days of labor. Although your body was still and cold, your kisses felt warm and your beauty gleamed like endless rays of sunshine in the delivery room. Your life will forever inspire me to be a mother who is self-loving, compassionate, dependable and above all else grateful. A woman who is resilient yet deliberate about optimizing her health and being good to her body. The experiences we shared are not only memories but like maps, they guide me through tough times. In my final semester of undergrad when I thought I couldn't persevere through an exam or complete the final requirements for graduation, rubbing my belly to feel your kicks and reading to you was how I met my goals. Your father and I anticipated your arrival from the very first day we learned of your conception and on the day you were born, we were not prepared for the greatness you presented us with.

To the facilitators of Hilary's open casket funeral and the vocalist who sang "Great is Thy Faithfulness" from the version introduced by Donnie McClurkin, thank you. Your professionalism and empathy helped my family and all who were in attendance cope with the sorrow that filled each pew. Also, many thanks to the medical practitioners and nurses who facilitated my labor and delivery, kept me relatively comfortable and informed me of changes along the way.

Lastly, special thanks to Autumn, Summer, Spring and Winter whose voluntary participation in this study are greatly appreciated. You gave me the opportunity to operationalize a theory whose potential validity may help many others. Your voices have become a useful guide to identifying the shared experiences related to stillbirth and miscarriage. It is my hope that this

work inspires the field of research related to Black studies, public health and the reproductive health of African American women in the United States.

ACKNOWLEDGEMENTS

Most importantly, I must acknowledge the support and guidance of my committee Dr. Jamae Morris, Dr. Sarita Davis and Dr. Kimberly Farris. Without your wisdom to guide me along the way and support to help motivate me through challenging times, this study would only lay dormant in my dreams. Thank you from the bottom of my heart.

To my partner in life, Ricky Warren Jr., your support as a loving companion and tremendous father have provided me the opportunity to gain success by doing that which I have the greatest passion, learning. Vivian Journi Warren, you are the miracle that brightens my life. Your beautiful smile has been a source of motivation, your life a daily dose of joy for my soul.

TABLE OF CONTENTS

1 CHAPTER 1: INTRODUCTION

While infant mortality rates have decreased nationally, the rate within the African American community has steadily climbed. Per the Centers for Disease Control and Prevention, the current rate of infant mortality among Black mothers is approximately twice the national average, despite a decade long initiative to address this phenomenon (CDC, 2013). Available data suggests that middle to high income African American women are more likely to experience infant loss than women of any other ethnicity or economic background, including White women (Lundquist, 2014). African American infants are twice as likely to be born pre-term and are still two times more likely to die compared to infants of any other racial/ethnic group (Byrd, 2007). These statistics remain true for women who have received higher educational degrees and those whose earnings rank them as middle and upper class (Farris, 2014). The current study seeks to add to this body of literature. Using qualitative methods, this study hopes to understand and explore the experiences of African American women with higher levels of income and education who have also been victims of pregnancy or infant loss while examining their expressions of stress experienced over the life course. The experiences and stories of middle and high income African American women are often left out of national dialogues about infant mortality and related social determinants of health. Capturing the voices of these women can contribute to ongoing efforts within African American studies and public health to close the gap in negative birth outcomes. A consideration of future research around African American women's reproductive health and birth outcomes that also includes an investigation of their inherent stress and resiliency through adversity will also be discussed.

1.1 Background

Historically, since the onslaught of slavery, Black women were blamed, and their morality questioned when they became ill, lost a pregnancy or were found to be sterile despite their deplorable living conditions (Washington, 2006). Statistics as recent as 2013 reveal that the rate of infant mortality among Black mothers is approximately 2 times that of the national average (CDC, 2013). Despite a decade long initiative to address this phenomenon, while the national average has seen a consistent decrease, the rate within the African American community has steadily climbed (Lundquist, 2014). The research conducted in this study is twofold in that it seeks to generate awareness about the infant mortality disparity in the US and identify links between stress, racism and class status. The most widely asserted cause for negative reproductive health outcomes, particularly for African American women, is *low* socioeconomic status (Giscombé, 2005). According to an annual report conducted by the American Psychological Association in the United States, socioeconomic status (commonly referred to as SES) is a marker of a person's social standing and is generally determined by combining one's education, income and occupation (APA, 2007). Until the 21st century, it had been consistently reported and announced through various news channels and print media that women who live in poor neighborhoods and have inadequate health care coverage are more likely to have poor health outcomes, including infant loss (Carty, 2015). These women typically get discussed as those who are in the business of reproducing babies solely as a means for free resources provided by the government in the form of welfare (Mullings, 2005). Their socioeconomic status is also coupled with the assertion that for various reasons, they do not receive proper prenatal care within the first trimester of pregnancy, leading to complications during gestation (the period of pregnancy usually lasting 40 weeks) (ASTHO, 2012). The story is further skewed by data which draws

connections between having low socioeconomic status, purposely living in neighborhoods with exposure to environmental contaminants and prolonging prenatal care. This troupe is both skewed and short sighted for several reasons including the persistence of this disparity among African American women with *higher* SES, who typically have greater access to healthcare and other medical resources.

1.2 Problem Statement

Given widespread advancements in prenatal healthcare (i.e. affordable healthcare plans, programs and services that provide transportation to medical centers etc.), educational attainment and income increases, there should also be improvements in birth outcomes for all women. However, previous research acknowledges that African American women with higher access to these resources are at the greatest risk (Farris, 2014). The larger implications within this study challenges current prenatal care standards for considering how often African American women who are upwardly mobile in their careers, experience racism on the job in addition to that within the general cycle of living day to day and the extent to which this might indicate their exposure to higher levels of stress during pregnancy. Furthermore, this highlights the need for inquiry into the lives of African American women who experience infant loss despite technological advancements and consistent access to care including considerations of the possible ways in which they are desensitized to otherwise traumatic levels of stress and therefore cope at higher than advised levels, potentially causing the loss of their pregnancy due to miscarriage or still birth. The narrative missing from research is that of the social mobility of those who work to care for themselves and others at a young age and who despite obstacles, manage to improve their social status educationally and economically over the life course. The implications of physiological disadvantage to African American women's bodies via stress and the efforts

exerted to manage fluctuations over the life course may provide a well paved path to ending the disparity of infant mortality.

1.3 Purpose

This study used qualitative interviews to examine the relationship between racial and or class-based stress accumulated over the life course to identify links between negative birth outcomes for African American women with higher paying jobs, higher levels of education, degrees and certifications. By drawing connections between experiences with racialized or socioeconomic stress and high efforts exerted to manage constant encounters with stress, the purpose is to identify potential patterns experienced over the life course that may have negative effects on birth outcomes for African American women with higher SES. While the methods used cannot suggest causation, they do make space for insights and considerations regarding race-based stress that are missed in other more quantitative studies (Brown, 2016). This research represents an endeavor to contribute to public health initiatives that seek to eradicate infant mortality in the US. The findings and field notes collected in the study are intended to contribute to multiple efforts. Mainly, the establishment of federally funded programs initiated to leverage the social context and theories within African American studies aimed towards better outcomes for the wellbeing of the African American population within the United States. The proposed study contributes both to public health initiatives and to the field of African American studies by generating a discussion about the physical effects of racism and class based stress accrued over the life course. The lasting impact of this study aims to empower the participants by providing helpful avenues along the journey through coping, by giving them a platform to have their stories heard. The experiences of each participant in this study creates a dialogue that could inform,

educate and influence future social science research in the goal to combat the disparity of infant mortality in the Unites States.

1.4 Significance of The Study: Theoretical Framework

1.4.1 Applications in the academy

In her 2002 publication "Resistance and Resilience: The Sojourner Syndrome and the Social Context of Reproduction in Central Harlem," Leith Mullings offered research that sought to deconstruct notions of biological inadequacy on behalf of Black women. The most effective goal within this study drew upon the life of Sojourner Truth whose legacy exemplified true resilience and resistance against oppression and adversity. Of her many accomplishments, Sojourner's "ain't I a woman" speech in 1851 at a women's convention held in Akron Ohio was arguably her greatest legacy. Despite being born into enslavement she would eventually gain her freedom and spend her life as an avid abolitionist. The context of this speech addressed the learned behavioral reactions to constantly accommodating stress at the expense of one's own health for the betterment of others.

Fundamentally, Mullings contested the misnomer that negative health and birth outcomes were exclusive to poor black communities. Her study addressed a very important gap that eventually highlighted the phenomenon of infant mortality in women from both working and middle class, showing how subgroups were equally affected despite increased education and access to healthcare. It went a step beyond focusing on the environmental factors of structural racism to confront the inequities which Black women face within the workforce and beyond as they continue to overcome stress driven by racism, class and or gender at any given time.

Additionally, intersections between Sojourner's assertions and the folklore of John Henry have been leveraged to create a discourse around the damaging effects on the mind and body,

characterized by racial and gendered oppression (Mullins, 2002). The moral to John Henry or "John Henryism" as referred to in various research journals is that active coping with stress, or chronic stress, leads to over exertion having negative and even fatal health outcomes.

1.4.2 Leveraging the Sojourner Syndrome as a framework to drive the literature researched and reviewed within this study

To sufficiently address the underlying variables that target the health of Black women's bodies requires a theory that can operationalize multiple themes that span beyond the superficial layer of one-off life experiences. For this reason, this study leverages the Sojourner Syndrome to interpret the paradigms created at the intersection of race, class and gender. This theory is referenced to apply a conceptual lens and to address the emerging issue that being Black and being a woman pose as risk factors of infertility and pregnancy loss, specifically miscarriage and stillbirth. As a framework, this theory primarily considers how the intersectionality of race, class, and gender effects the lives of African American women who somehow manage chronic stress while continuously encountering stress . In 2014, it was used to gain a better understanding of how these factors influence HIV/AIDS risks for Black women (Davis, 2014). Davis contends that this method is more accurate when seeking to understand disparities by acknowledging its complexity versus relying on statements of lifestyle choices. Most importantly, the Sojourner Syndrome provides a lens to go beyond simply identifying the well-known attributes of racism by examining how the culmination of race, class and gender produce health effects. Given this harsh reality, it is important that the literature that informs research related to Black studies and women's reproductive health consider the implication of sociopolitical factors related to experiences with racism and the increased physical consequences of that stress on a child bearing mother.

1.5 Research Questions

1. How do African American women with higher socioeconomic status conceptualize their levels of stress before and during a pregnancy that ended in miscarriage or stillbirth?
2. What styles of coping do African American women with higher levels of income and education engage in during pregnancy?

2 CHAPTER 2: LITERATURE REVIEW

2.1 Historical Analysis: Negative Health Outcomes and African American Women

To understand the full scope of female reproductive health amongst African American women, an overview considering the history of enslavement is necessary. Beginning with the arrival of enslaved African men and women in the early 17th century, there became a value system established in what would later become the United States of America, placing financial worth on their bodies. Subsequently, this system made it so that the health of these men and women whose livelihood had been stripped from them, was contingent on their ability to be auctioned as property. The construction of this process lasted through several generations, altering the physical and chemical properties in their biological makeup leading to negative health outcomes that still plague African American lives disproportionately to people of other ethnicities (Washington, 2006). By using the term ethnicity throughout this study, the hope is to uncouple the connection between race and biology by instead focusing on the ways in which external factors have shaped the health and mortality of African American people (Giscombe, 2005).

The source for this portion of research examines the establishment of medical practice to identify common themes and experiences as they relate to African American female reproductive health. Most of the basic medicinal drugs and antibiotics currently prescribed in the United States were invented as a result of human experimentation. The largest population of human subjects were African American men and women who had no rights and thus no ability to reject their participation in lab tests and unnecessary surgeries, usually conducted in unsanitary conditions (Washington, 2006). The lack of concern for the health and well-being of enslaved African Americans, outside of its relation to the wealth of their masters, is especially evident

when reading archives of medical records. Publications of these records indicate negligence from doctors and practitioners who for example nonchalantly noted the anguish of a "slave woman" forced fed bleach to examine the effectiveness of regurgitation, when met with widespread epidemics like the common cold (Washington, 2006). These and other unethical practices were the norm when conducted on black bodies in conjunction with the conditions of daily hard labor, generally associated with chattel slavery.

In addition to having equal performance standards and expectations as their male counterparts, enslaved African American women were also the literal bearers of the human workforce. Their wombs represented the proverbial "manufacturing house" of future "slaves" especially after the enactment of the Slave Trade Act of 1807, which essentially banned the exchange of "slaves" through the Trans-Atlantic slave trade (Reddie, 2010). Since it had become illegal to bring new ships of Africans to American shores, plantation owners shifted their strategies to domestic production, relying on the practice of breeding to reproduce. Although the practice of birthing slaves became an industry on its own, there is little evidence that any consideration was made to provide healthcare to African American women before, during or after delivery. In fact, by the late 19th century, the infant mortality rate for "slaves" living on mid-size plantations had reached 25% (Steckel, 1979). Records of these infant deaths was noted as blame towards the mothers' "moral and intellectual failures" (Washington, 2006). However, it's more likely that maternal and infant death occurred because of infections relating to hygiene and the bacteria accumulation within the parameters of their living quarters. Also, more often than not, doctors did not follow sanitary guidelines such as washing their hands or surgical tools (Washington, 2006). Instead of considering their deplorable environment or the psychological effects of enduring strenuous labor and surgeries without anesthesia (even though it was

available), the common response towards African American women was ill regarded (Washington, 2006). This dynamic properly introduces and supports the theme used throughout this proposal which seeks to explore race-based factors such as stress and gender roles that cause health disparities predominantly effecting African American women. The women who survived this history, left behind a legacy of resilience as well as a blueprint to reference health inequities, especially for the reproductive health of African Americans living today. Applying this conceptual lens supports the proposed strategy to explore the long-lasting effects of particular life experiences over the life course which may be related to gendered stress and complicated by racially based factors that contribute to the likelihood of high effort styles of coping.

2.2 Present Day: Implications of Racial Stress on Reproductive Health Outcomes

With the turn of the 21st century, the outcomes for reproductive health among African American women have become far less grim. In fact, there have been many technological and medical advances that have improved the overall health and life expectancy of all US born women within the last 100 years (Giscombe, 2005). Still, infant mortality specifically stillbirth and miscarriage disproportionately affect African American women despite external factors that universally impact women of other ethnicities (Kitsantas, P., & Gaffney, K. F. 2010). Additionally, according to a 2005 study based in California, while the national average for infant mortality has steadily decreased since 1971, the rate for African American women has continued to steadily increase during that same time frame (Hessol, N. A., & Fuentes-Afflick, E. 2005). Advances in research highlight the need to consider how race related stress is imposed on African American women due to the intersection of environmental factors such as racism, sexism and gendered stress (Jackson, 2012).

2.3 Speculating the cause

In more recent years, valuable research on the inconsistency of knowledge in regard to variances in these outcomes within subgroups has exposed gaps in research that do not fully address the increasing infant mortality rate for African American women with higher socioeconomic status (Farris, 2014). In 2012, Author Fleda Jackson developed a contextualized stress tool to test the stress levels in 101 pregnant black women to examine the extent to which they were affected by contextualized stress, global stress and depression (Jackson, 2012). To show the cause-effect relationship between these stressors, this study deemed that there were three conceptual approaches to identifying racial stress and gendered stress. Even more valuable are the measures within recent research that increasingly quantify differences in stress types, showing residual effects of structural racism and other racially charged factors. Still however, there continues to be a need to qualify these experiences to construct the larger narrative that impacts so many women and help inform even more about their risks for negative birth outcomes.

2.4 The Balancing Act: Chronic stress and allostatic load as implications of negative health outcomes

For decades, scientists in various fields of study have continued to investigate the biological and physiological processes of the human body. Researchers exploring the physiological risks associated with chronic stress, collectively use the allostatic load as a measure of normal body part functioning which provides a means to capture wear and tear (Robinnete, 2016). The body's natural and involuntary process of balancing the release of hormones to maintain stability is medically known as "allostasis" (Sterling,1988). The repeated

exposure to fluctuations in stress, known as the allostatic load, represent the outcome of instability in the attempt toward achieving this balance or allostasis.

In 2017, a study focused on examining the links between discrimination and anger control, identified disadvantages to the body's physiological progress of managing stress known as the allostatic load (Zilioli, 2017). The findings highlighted significant connections between socioeconomic disadvantage and perceived discrimination. According to the authors, data collected from 909 participants revealed that perceived discrimination and high levels of effort to control anger "sequentially explained the relationship between socioeconomic disadvantage and allostatic load" (Zilioli, 2017).

Allowing participants to discuss encounters with stress related to perceived discrimination and socioeconomic status are at the core of the design for the interview questions used in the current study. Giving African American women a space to reflect on their experiences with trauma, anxiety, racism and climbing the social ladder, may shed light on how often their bodies were under pressure to maintain balance over the life course. Their resiliency in the ability to achieve educational and economic success despite these potential circumstances are implications for resiliency which will be further explored in the discussion chapter of this study.

2.4.1 Data consistency proves African American Women with higher education have highest rates of Pre-Term labor and Low Birth Rate

The most integral findings in recent research shows that fundamentally, the main causes for infant mortality in the US are preterm labor and low birth weight. Per the Association of State and Territorial Health Officials, low birth weight is defined as "an infant born weighing less than 5.51 pounds" (ASTHO, 2012). Pre-term labor, defined as an infant born before 37 weeks'

gestation, is the second most prominent cause of infant death resulting in stillbirth. Both factors are proven predictors to infant death (He, 2015). A study conducted last year comprised data from states in the south-east region of the US looking for infant death trends occurring between 2005-2009 amongst all women. The findings indicated that women with approximately 16 or more years of education experience an infant death rate that is more than twice that of the overall average (He, 2015). Although this study did not specifically focus on racial inequities, it provides significant attention to the link between pregnancy loss and higher socioeconomic status. In another study also centered in Mississippi, a southeastern state, analyzed the linked birth/death certificates for 202,931 single births and found that Black mothers were disproportionately affected by heart disease and hypertension causing the preterm labor and low birth weight of their infants (Graham, 2007). Both diseases were shown to pose increased health risks exclusively for the Black mothers in the study.

2.5 Gaps in current research

The shared limitations within research occurring over the past two decades indicates that more focus is needed to qualify infant mortality disparities within major ethnic groups. Generally, comparisons have been studied amongst largely represented groups such as African American, Hispanic and non-Hispanic White women due to their accessibility (Association of state territorial health officials, 2012). However, even when common factors such as income and educational attainment are controlled for in research studies, the disparity becomes more evident within African American subgroups such as those within the middle and upper class, despite the wide spread assumption that social climbing successfully improves birth outcomes (Farris, 2014). Additionally, due to inequities in access to essential resources (i.e. food, housing etc.) along with the widening wealth attainment gap between African Americans and non-Hispanic

Whites, these two groups may not be comparable enough to provide significant data to identify the cause of disparate rates of infant mortality across ethnicities. In the case of non-White Hispanics when compared with African Americans, disparities in low birth weight and pre-term labor continue to exist despite the two groups having similar "risk profiles" (Alio, 2011).

The 21st century overall health outlook in the United States shows that African American women overwhelmingly experience higher rates of ailments such as diabetes, AIDS, heart disease and as focused within the proposed research, infant mortality (Davis, 2014). In 2014, Dr. Kimberly Farris conducted research designed to "promote positive reproductive health outcomes." Her discussion promoted a communication campaign plan to combat adverse birth outcomes among higher socioeconomic status [SES] African American women, the subgroup shown to be most significantly targeted by infant mortality (Farris, 2014). Her study on health took the imperative action of creating an initiative to address the limited literature on the subject by increasing awareness through education both to the African American public as well as medical professionals and policy makers.

2.5.1 Determining racial stressors and defining coping styles as high effort

A 2011 study focused on examining the social context of adverse birth outcomes and reproductive disadvantage of African American women, identified the implication of racism as stress. As other authors, have noted, racism is both a stressor and a stimulant that "heightens one's exposure *to* and impact *of*" more stressors (Dominguez, 2011). This fact alone may help shed light on the experiences of the participants within the current study when their memories are explored over the life course with regards to race but not gender. As stated throughout this review, preterm labor is the most prominent cause of infant death and in 2005, author Carol Hogue made a significant contribution towards identifying the impact of stress on preterm

delivery, particularly for African American women. By determining the connection between maternal stress and negative experiences during child birth she subsequently made significant claims towards the impact of stress over the life course. This article also asserted that due to the neurological effects of stress among other outcomes, a women's reproductive organs may age prematurely due to the result of cumulative stress and or traumatic events (Hogue & Bremner, 2005). Even more interesting is the suggestion that in regard to life history, traumatic events experienced early in life accumulate over time and have significantly shown to yield physical effects on pregnant mothers leading up to labor, prescribed as hypertension and causing pre-term labor (Hogue & Bremner, 2005). It has been hypothesized in other studies that chronic exposure to racism and the social limitations it produces, especially when compounded by contemporary forms of stress has damaging effects on the female reproductive system (Dominguez, 2001). What can potentially be said about this phenomenon then is that these women's overexposure to stressors like racism before becoming pregnant and during pregnancy may desensitize them to new stress they encounter, causing them to cope with such stress with higher than normal psychological and or physical efforts. Furthermore, an increased level of stress presumably increases the effort that one must put forth to cope with their experiences daily. More research is needed to investigate the unacknowledged effort that potentially overshadows the amount of stress a pregnant African American woman with higher SES may be under and account in partial to disproportionate experiences with preterm labor and negative birth outcomes.

2.6 Need for current study

2.6.1 African American Women, Socioeconomic Status and chronic stress over the life course

There have been many important research studies that address the damaging effect of stress on the human body within the field of social science throughout the last century. By extending this inquiry to further explore the relationship between racism, gender, stress and the reproductive maternal health of African American women, studies have increasingly identified key connections (Jackson, 2012).Within the last 20 years, researchers have examined the ways in which stress caused by intersections between race, gender and class affect the disproportionate rate of negative birth outcomes experienced in the African American community in relation to other ethnicities (Giscombe, 2005). Within the last five years, research has significantly begun to focus on identifying the link between racism and stress as the prominent factor leading to negative birth outcomes in pregnant women. However, the general narrative used to explain the negative birth outcomes amongst African American women points to socioeconomic factors. It is most commonly assumed that African American women with lower income and minimal education account for the highest rates of infant mortality due to limited access to healthcare and poor lifestyle decisions (Dominguez, 2011). While this theory has been challenged through various quantitative studies, perhaps employing a qualitative approach to discuss personal experiences may furnish research which exposes concrete solutions and lead to higher rates of positive birth outcomes for African American women. A focus shift to race-based disparities has been applied to this research topic to consider the psychologically stress induced avenues that lead to pregnancy loss and infant death for African American women with higher SES. Instead of focusing on the economic disadvantages of socioeconomic status, the task is to explore the

particular experiences of African American women with higher SES, with respect to their roles in society, in various relationships, and within various occupational realms as it relates to gendered stress and stress caused by racism. Increased socioeconomic status theoretically yields benefits in accessing resources like stable transportation, home ownership and income stability. Even with these attributes, Black women continue to experience the loss of their unborn or recently born babies at twice the rate of the national US rate (Lundquist, 2014).

A significant obstacle in understanding the impact of stress is identifying racism and gender as stressors that yield negative birth outcomes. According to an increasing body of literature within the field of psychology, women who experience high stress and high anxiety during pregnancy, also have a higher chance of delivering infants who are either preterm or who have low birth weight, the 2 main causes for infant mortality in the US (Guardino, 2014). Due to the limited availability of research specifically linking unique stressors such as the racism Black women experience as their income, education or class status improves, this study strives to explore the cause for the potential stress that they each face. An added quest is to explore the ways in which a Black woman is further disenfranchised by her gender as an attempt to understand how one's encounter with stress begins and continues throughout the life course then potentially effects their reproductive outcomes

3 CHAPTER 3: METHODOLOGY

3.1 Design

3.1.1 Setting

Per the US Census Bureau, the census takes place every 10 years and is used to count each resident in the United States for future use in determining political influence and financial distribution (U.S. Census Bureau, 2010). In 2015 the estimated population of African American women within the state of Georgia between the ages of 25-45 totaled approximately 460,349 based on projections from the most recent data collected in 2010. As of 2015, there are more than 580,000 African American women between the ages of 25-45 who work year-round with an income that meets or exceed $50,000 per year and have earned a bachelor's degree or higher in the United States. Atlanta is one of the largest metropolitan cities and is in Fulton country whose current African American population is 44.1% (U.S Census Bureau, 2015) housing several historically black and predominantly white universities. Due to my immediate access to Black women with increased access to education and gainful employment as a resident of Atlanta, Georgia, this location represents the setting for the current study.

3.1.2 Participants and Recruitment Process

A purposive sample of 4 self-identified African American women between the ages of 25-45 who have experienced miscarriage or stillbirth will serve as the focus of inquiry. Particular criteria are in place to ensure that the participants have the shared experience with loss although potentially at different stages. Due to the sensitivity of the research subject, each woman was provided with a consent form to acknowledge their agreement to partake in this study given the potentially traumatic undertone of the topic. Since it is possible that each participant may experience emotional and even psychological discomfort in the process of discussing their

experience with infant loss, the time since the loss must exceed 2 years. This is put in place as a general parameter to prevent any interruption of the beginning stages of the grieving process. Initial participant recruitment was conducted based on previous associations and or conversations with the researcher that have come up in passing which identify them as appropriate candidates due to their socioeconomic, gender and racial status. Further measures include a requirement that each participant acknowledge that they've sought out and received therapy or taken other self-healing measures prior to consenting to take part in the current study.

3.1.3 Procedure

The basic structure of this study leverages the narratives of 4 women who are open to describing the memories, actions, emotions and reactions they have experienced because of losing their child during or post pregnancy. Each participant completed an initial questionnaire to ensure that they meet the criteria designed to validate the data collected during interviews. The main criteria that must be met for participation in this study is that the loss has occurred 2 years before their participation [<1/1/2015] and acknowledgement that they have sought out some sort of therapy or self-healing for coping purposes. Face-to-face interviews were conducted in the location of each participant's preference. The interviews took place throughout the course of 1 month and all audio was recorded during each session. The data received after all interviews for the study had been conducted was transcribed, coded and presented to the participants to ensure the accuracy of the descriptions used to represent their experience.

3.1.4 Questionnaire

The questionnaire in this study was utilized to ensure that each person is qualified to participate by confirming that they meet required criteria. The instrument was compiled using basic SES standards to assess each person's identity and economic status for initial purposes, and

to identify potentially common themes after all data has been collected (APPENDIX B). Each participant received the questionnaire immediately following receipt of their signed consent forms. This form served to ensure that each participant meets the basic demographic and experience criteria required to add value to this study.

3.1.5 Interviews

This process is intended to identify clearly what each participant experienced because of their loss, while encouraging discussions about how they reacted. The questions asked in this study were designed to encourage participants to be transparent as they describe memories, emotions and actions. The interpretation of these experiences was conveyed using a narrative approach which allows for optimal reflexivity. Furthermore, the intended function of this study is to place an emphasis on the voices of these women and their experiences in such a way that provokes both a sense of inquiry and empathy. Each interview lasted at least 90 minutes. The main approach of this process is an intersection between conversational and in-depth qualitative interview styles to increase the likelihood that the data will be rich in content. The interview guide is included below (APPENDIX C)

3.1.6 Interview Procedure

1. Contact the potential participants to determine if they are interested in participating in the study.
2. Schedule time with participants for the interviews.
3. Have the participant read and sign the informed consent forms immediately before interview begins.
4. After signing the consent form, the participant will complete the initial demographic survey to determine their eligibility to participate based on the criteria requiring that

they've experienced a loss, the loss has occurred before 1/1/2015, and that they've sought therapy or self-healing.

5. Provide participant with blank timeline worksheet.
6. Record the interviews using audio device.
7. Collect timeline worksheet after each interview session.
8. In this study, participants may experience heightened emotions and regress to early grieving stages due to unfavorable memories of the loss of pregnancy or an infant. Before participation, the participant may want to speak with a physician or therapist to ensure mental stability for this process. Due to the qualitative nature of this study and to assure accuracy, all audio from each interview will be recorded, transcribed and coded. No voice alteration will be conducted to modify one's voice. Each participant will be provided with an option to receive an informational pamphlet from the Share Atlanta organization who specializes in support initiatives to mothers across the United States who have lost children due but not limited to miscarriage, stillbirth and SIDS. If at any point the participant becomes angry or upset, they will be offered the opportunity to discontinue participation. I will attempt to empathize by sharing my own experience and the emotions I've dealt with in the process. A short script has been added to the interview procedures to acknowledge the sensitivity of the topic and validate any emotions relating to the memory of loss.

"I know this is a very sensitive subject. I admire the strength that it takes to discuss the emotions you felt at the time of the loss while being willing to deal with those same emotions as they resurface in memory of the experience. You are so brave for coming this far and I completely understand and respect your decision to end the

interview if you wish."

SAMPLE SELECTION: HUMAN PROTOCOL CONSENT (APPENDIX A)

In addition to being self-identified as non-Hispanic Black or African American, this study requires that the participants meet the following criteria:

1. Have had a pregnancy that ended in loss at any stage in gestation from conception (i.e. Miscarriage, stillbirth) before 1/1/2015. The loss must have occurred at least 2 years prior to their participation in this study.
2. Has completed some form of therapy and or self-healing to come to terms with the loss before agreeing to participate in this study.
3. Understands the potential risks associated to discussing the sensitive topic proposed and unearthing emotions associated with the loss.
4. Each participant will be provided with an option to receive an informational pamphlet from the Share Atlanta organization who specializes in support initiatives to mothers across the United States who have lost children due but not limited to miscarriage, stillbirth and SIDS.

3.2 Data Collection Techniques

In addition to the data received in the questionnaires, audio recordings were used to tape each interview conducted per participant. Each participant was asked to sign a consent form acknowledging their acceptance and willingness to participate. After gathering all recordings, the researcher reviewed each audiotape, then transcribed each interview. After the transcription process, each participant was given the opportunity to review their interview transcriptions to confirm that their experiences were captured accurately. All transcriptions were then coded for later consideration to determine common themes relative to the research questions previously proposed.

3.3 Data Analysis

Analysis of interview data included two steps. First a review of the participant's interview and second, a review of each individual life course timeline. Once all interviews have

been conducted, the analysis of the collected data will begin with a review of each participant's timeline worksheet. All data collected from each interview will be entered into a program called Dedoose, a data analysis software program. Afterwards, a comparison review will take place to identify any shared experiences in regards to identifying particular experiences as stressful in the years before becoming pregnant, as well as if there are any experiences that yield significant data during the time of their pregnancies with regards to their gender, racism or fluctuating class status. Any apparent themes will then be coded to begin the process of identifying relevant patterns as they relate to coping and the subsequent experiences this yields over each participant's life course. This step will also yield a visual representation of each participants experience in the form of a timeline, any reoccurring themes will be incorporated into the results. This analysis decision was made because of research conducted on its benefit by Maltz and Mullany (2000) which asserts that despite individuals experiencing similar events, in the case of the current study miscarriage and or stillbirth, methods that consider the variations in the way each event occurs is best presented by showing patterns when using life course models. A table which illustrates different domains of a person life with special attention to making clear distinction of the process associated with each life event. Creating this aggregated timeline which highlights the age of key life events along with the emotional reaction and or coping styles used during each experience will be the final step.

3.4 Generalizability

While research that studies maternal stress is ever present within the field of social sciences, this study applies a life course model to qualify the unique stressors and or stressful experiences African American women have encountered based on their role in the family, personal relationships and within society. As with any small scale qualitative study, the results in

this study will not apply to the general population and thus will make it less likely to generalize African American women with higher SES outside of the greater Atlanta area.

Instead of focusing on biologically determined factors, the research conducted in this study seeks to examine external factors that may unequivocally target African American women and lead to negative birth outcomes. The body of research that has begun to highlight the infant mortality disparity within ethnic subgroups disproves that upward mobility directly improves birth outcomes (Farris, 2014). In fact, African American women who are more educated and have higher income than poorer and less-educated African American women are even more likely to experience negative birth outcomes.

4 CHAPTER 4: CONCLUSIONS

4.1 The Participants

Winter. Winter is a 33-year-old mother of 3 who currently leads an early childhood learning center as a Director in Norcross, Ga . She has had a total of 2 pregnancy losses in her life time and openly discussed the painful memories of each during the course of the interview. Winter first became pregnant at the age of 24 soon after beginning her career as a teacher. One day during her eighth week of pregnancy, she began bleeding while at work. She made her way to the emergency room where she was told that her body had begun the process of miscarrying her unborn child. For months that followed she fell into a deep depression feeling mostly guilty for her inability to bring a healthy child into the world. She mentioned that with this also came a feeling of failure which took a long time to overcome. Her second loss occurred 3 years later at the age of 27. Due to her history, the pregnancy was confirmed early on and had gone smoothly until she reached the 4th month. She remembers not feeling a lot of movement and being told by doctors that each baby is different and not to worry. During her fifth month of pregnancy she began experiencing swelling in her legs and fingers. One day the swelling was accompanied by fatigue and she knew something was not right. When she arrived at the emergency room she was immediately admitted and placed on IV. As the doctors checked for the baby's heartbeat she remembers hearing a faint sound of beating and then drifting off to sleep. When she awoke there was no baby. When she fell asleep the baby's heartbeat had fallen and the Doctors decided to do an emergency C-section, but the baby had already passed away. Due to the baby being stillborn, they removed the body from the operating room. When Winter awoke she was understandably in shock and despair. Amazingly however, despite not ever laying eyes on her baby, she made the

selfless decision to donate the body for stem cell research to help others in need. Her strength and resilience of this and other experiences made her an asset to this study.

Spring. Spring is a 29 year old mother of 2 who has built a company as an entrepreneur in the financial industry. She first became pregnant at the age of 18 with twins. She found out about her pregnancy due to a missed period and a subsequent pregnancy test. Her boyfriend at the time was scared and tried to convince her to terminate the pregnancy but she refused. At the time, she was working as a C.N.A, taking classes online and living at home to support herself and siblings in her mother's sporadic absence. The pregnancy ended in miscarriage before the end of her first trimester with the passing of one twin occurring days before the other also known as vanishing twin syndrome. Three years later, she had a second miscarriage during her eighth week of pregnancy.

Summer. Summer is a 37-year-old elementary school teacher with 2 daughters. She has had 2 miscarriages, the first occurring at the age of 24 during her final semester in college when she was eight weeks pregnant. Several years later when she was 30 years old, she had a second loss which also ended in miscarriage during the first trimester.

Autumn. Autumn is a 47-year-old business professional who became pregnant for the first time at the age of 34. She met her husband in her late twenties and they both agreed to travel and build their relationship together before having children within the first few years of marriage. From what she remembers, the pregnancy was mostly uneventful in terms of sickness of any sort. Unfortunately, when she was three months pregnant she began bleeding while at work one day. By the time she made it home, she noticed that the blood had not lessened so she went to the emergency room. She waited for an hour to be seen but suddenly felt the urge to use the bathroom. Since she hadn't yet been triaged, she was given a metal bowl to release herself in so

that the appropriate labs could be conducted on her urine for standard testing purposes afterwards. The miscarriage happened in the bathroom during this time and she was forced to carry her unborn fetus into the room to show the doctors. Hearing her story was incredibly emotional and equally as powerful.

4.1.1 General Demographic Information

A total of four interviews were conducted and the data from each session was analyzed. Of the four women interviewed, all but one has obtained a college degree from an accredited university at the Bachelor's level. One participant has achieved a Master's degree, two a Bachelors' and one participant has a high school diploma but comparative education in her professional career. The average household income ranges between $31,000-$75,000 and the current ages range from 27-47. The age at first pregnancy ranged from 18-35 and all losses in pregnancy have occurred more than two years ago (<2015). Each woman expressed that while some of their pregnancies were planned, the initial one was not. Additionally, of the four women participating in this study each of their first pregnancies ended in miscarriage. Each woman has had multiple losses which ended in either miscarriage or stillbirth. All women continued to work to support themselves and others before during and after their pregnancies.

The socioeconomic status of each woman was self-reported via preliminary questionnaires and surveys. Based on educational attainment and income status, they rank among the mid to high level SES however, their experiences over the life course indicate an upwardly mobile trajectory filled with constant encounters with stress along the way. Although they've achieved an economically stable lifestyle, upward mobility continues to be a daily task for each woman. Their experiences discussed during interviews create a narrative that considers the unspoken challenges and accomplishments that occur in the transition through class barriers.

Their child loss experiences are explored to begin a discussion about how to properly situate the lived experience of African American women when considering their disparity of infant mortality in the U.S.

4.2 Data Analysis

The data analysis process yielded several themes. Each support the larger narrative of stress accumulation over the life course and its relationship with social upward mobility as a significant factor in the lives of African American women who have suffered the loss of one or more pregnancies. Close attention was paid to the uniqueness of these experiences and the findings highlight the points at which their stories intersect. Each of their stories were situated within racial and cultural contexts and indicate an ongoing relationship with stress accumulation and active styles of coping through these occurrences. Of these themes, the most commonly reported were childhood trauma, working to care for others and views towards motherhood based on mother-daughter relationships.

4.2.1 Childhood trauma

Learned behaviors are arguably inevitable within the social environment of one's household. Watching our parents, peers and other impressionable figures in many cases, defines the way we ourselves respond and react to situations and events. If for instance, a child observes domestic violence on a regular basis between their parents, their social behaviors may be influenced and whether they identify with the abuser or the victim is left up in the air. On the one hand they may ignore any emotions or feelings and attempt to erase the memories from their minds choosing instead to seek distractions that help to escape their reality. On the other hand, they may engage in self-inflicting violence that places them in an extended phase of danger. In either case, it is important to recognize that in neither example has the child been provided a

context to situate their experience and directly acknowledge how they feel and more importantly how to define and manage those emotions. Consider the long-term effects this may have on the child's ability to lead a healthy life. How might the learned behaviors from their experience inform how they address conflicts or otherwise demanding situations of their own? Watching parents or other family members behave, typically informs our own behaviors. The resounding notion expressed across multiple interviews was that seeing Black women react to adversity with an attitude of resilience on a consistent basis set an expectation of strength that shaped their own roles in society. A suggested byproduct of the Sojourner Syndrome, subscribing to abnormal or even unrealistic ideals of bravery was referenced as a key strategy leveraged to cope with stress. The suggested impact of this internal conflict is an increased reliability on one's self thus higher efforts exerted to cope with stressors as they arise. Keeping one's self busy to avoid the inevitable confrontation of fears and emotions was one such behavior expressed in each of the four interviews and sheds light on a key factor in identifying styles of active coping.

Many of the women in this study have not only witnessed domestic violence in their homes, but have been simultaneously managed responsibilities that are normally held by adults. From staying at home alone or providing care to siblings in the absence of parents or guardians for days at a time, these women have shared an experience of being under constant pressure to perform. Yet it is their perseverance that has allowed for their ascent through class status.

Autumn was only six years old when she began walking home from school then rushing in the house to ensure that the door was locked securely behind her until her parents came home hours later in the evenings. At nine, Spring was responsible for injecting insulin into her grandmother who was her sole caretaker during months when her mother's irresponsibility began to impact her own wellbeing. Winter had already begun to understand the importance of self-

reliance at nine years old, when she was abruptly taken to a boarding school and left until her graduation at the age of eighteen. By the time she was ten years old, Summer had already buried both maternal grandparents along with her own father whom she'd watched abuse alcohol until his death due to lung cancer.

> "My dad died from lung cancer when I was 12, he was always inebriated… an alcoholic according to my mother. Losing someone at the age of 12 you know you're young and you don't know how to process death, especially for someone who I didn't really know so I was kind of numb to the fact that he did die. I didn't cry for years actually…I didn't fully process that until I was probably in my early 20s."

To compound the emotional instability each woman remembered was the instances of molestation, racial discrimination and even neglect which were only a few key terms mentioned when asked to describe their earliest memories as a child. Having to confront either of these situations can be overwhelming but for all four participants, their experiences were compounded with events within the home. Winter recalled being violated and then reprimanded by her mother shortly after, "So I had a step-father and he had a son and he began touching me [breasts]…He was mentally challenged, 2 years older than me… My stepfather had 3 sons and they stayed at my mom's house. For some reason, they chose him to share a room with me and that's when and where it would happen." Instead of being offered therapy or at least the compassion of understanding once she decided to speak up, she was taken to the nearest boarding school a few weeks later and dropped off at the age of nine. Approximately five years before that, she had been standing in the living room when out of nowhere, a woman covered in blood ran into her home screaming. She had just struck a pedestrian and when Winter peeked out the front door, she discovered a dead man's body laying still in the middle of the street. Even still, the stressors were constant. Her parents divorced when she was five years old and she was sent to live with her Grandmother for five years. In that time, she expressed an immense sense of belonging and

happiness which was a stark contrast to what she felt in her years at boarding school. Despite her triumphs, she shed tears when retelling her story and acknowledged that the anger lingers from those memories and still manages to surface in her moments of frustration or when she's already under a lot of stress.

Each woman shared a story of defeat and triumph over the life course in an eloquent tone that conveyed resistance. Their stories were expressed vividly and were self-described as either traumatizing or stressful. Spring had to intervene in a domestic dispute between her grandmother and grandfather "He was a very abusive man, he drank a lot, and my most vivid memory of him was when he and my grandmother were having a dispute… well he picks up the receiver end of a rotary phone and proceeds to strike my grandmother with it. I was in the middle of playing and that scene occurs out of nowhere. I ran over and jumped on his back and was screaming "don't hit my grandmother." In her adulthood, she connected this memory to the way she interacted with men and others who she perceived to be in positions of authority. During her second pregnancy that ended in miscarriage, she fought off the persuasion from her boyfriend at the time to abort her pregnancy. Although she has accepted that there is no fault in the misfortune of miscarriage, she blames the stress from the relationship and that which she experienced as a result from maintaining a full-time job while supporting her younger siblings for the loss of this pregnancy.

For one participant, the suppression of her encounter with trauma was explicitly referenced as an attributed factor in the loss of her first pregnancy which ended during the beginning of the second trimester. When Autumn was 12, she had an impromptu visit to the gynecologist for menstrual preparation and has experienced lifelong anxiety as a result:

> "…there was a time right before "that time" and I was telling my mom about it and she had my Dad take me to the doctor …before they took me into a separate room, they made me take off my clothes to put on the robe with my dad in the room. I was 12 and as you can imagine, I don't know what to expect. This is the first time I'm at the OBGYN…So the doctor was like ok pull down your pants…. I got on the table laid back and the next thing you know I feel something being rammed up my vagina. I screamed so loud even the people in the other rooms could hear me… I was a virgin and had no idea what the appointment was going to be like. That was very traumatizing to say the least. That's probably why I didn't want any kids for so long afterwards…I got in trouble for disrespecting the doctor because I screamed for him to stop and that it was hurting. She [Mother] said I was raising my voice and was being rude. She chastised me for my reaction."

Although Spring disclosed less details regarding specific memories of traumatic events, she did reference the loss of her father and its contribution to her inability to confront emotions dealing with the associated pain and or grief.

The most insightful factor identified during the cross analysis of these stories was the shared experience of encountering a stressful event with little if any context to provide guidance in the process of navigating their lives. Furthermore, it is quite curious that three of the four women described an event that occurred at the age of twelve. Close attention was given to discussions where the words used to describe the emotional and or physical reactions related to stress and coping.

Essentially, these memories tell the story of actively coping with abnormal levels of stress while simultaneously carrying out everyday tasks. At no point did either woman indicate an intervention whereby therapy or otherwise meaningful discussions took place to help them process what they had gone through nor how to approach the feelings and emotions they experienced as a result. Instead, they referenced additional hardships and tragedies that happened within their household as they continued to paint the picture of their past. Furthermore, the common reference when each woman recalled her life history was the intentional decision to keep busy. By working harder to achieve success educationally or work to support parents and

siblings, they inadvertently learned the behavior of masking to cope with stress which may have put their bodies at risk physiologically. From here it is suggested that this process over exerted their bodies stress management system and may have potentially led to the negative birth outcomes they experienced in the loss of their first pregnancy. Much like the earlier reference to the fable of John Henry, applying the theories of the sojourner syndrome may explain how the cooccurrence of these experiences with the ever-present responsibilities based on their role in the family may have been the result relating to the dangers of active coping.

4.2.2 Working to Care for Others

The population of women represented in this study come from household environments where working to survive from one paycheck to the next was the only way to ensure survival. Earning a living and improving their social status was a task that required intrinsic and extrinsic motivation as the effort toward one did not directly ensure the ladder. The social construction of success generally implies that there is a comfortable transition from adolescence to adulthood in terms of educational attainment and collegiate pursuit. Going to college, participating in social activities and acquiring knowledge are themes that are promoted through many media outlets. They suggest a direct path to a lifestyle filled with financial stability and professional growth. What is absent from this depiction are the various means necessary to support such ventures. Parents are usually the first resource accessed to afford the ability for their children to go to college. For working class families or those who lack the financial means to pay for college must seek out other sources of funding. In the case of the women in this study working to support themselves through college was a requirement and not optional. For example, in Winter's case, not having the luxury of parental financial support to focus solely on studying meant maintaining steady employment to afford food, transportation, housing and the cost of college itself. This is

arguably stressful process and one that equally presents stressful challenges to overcome on a regular basis. Although demanding, the women in this study represent a collective mindset that proves it is possible.

Of the four women interviewed, two are married. Winter became married after the birth of her oldest living child and Autumn has been married for seventeen years. Spring and Summer have never been married but have had close interpersonal relationships with the fathers of their children and experienced gaps in dependability from those relationships. A consensus within similar research has confirmed the benefit of interpersonal relationships to one's wellbeing and improved health outcomes (Jackson, 2012). Adversely however, the results in this study support the assertion that the absence of this form of support requires more effort to cope with demanding situations and manage cooccurring forms of stress.

During their childhood, three of the four women were raised by a combination of their mothers and grandmothers. Each of the four women were children to mothers who had children during their teenage years. From their individually disclosed experiences, all women lived in low-income earning households. The communities in which they lived were predominantly African American, with households led by working class parents. None of the women had parents who achieved higher than a high school diploma. When asked to describe experiences of their roles in the family, unanimously all had begun working at an early age to support themselves and or others within their household. From these experiences, the women attribute a great deal of angst which they carried from adolescence well into adulthood as they simultaneously worked towards improving their livelihood. Despite the frequent adversities they faced including perceived racial discrimination or financial hardships attempting to pay for necessities and college, they succeeded in their ability to improve their social standing and

income. Unfortunately, although their income and education increased thus improving their overall access to quality healthcare, their experience with miscarriage and stillbirth prove that their health outcomes did not equally improve.

> "It was extremely stressful because I had to go to work and figure out a way to balance getting good grades and keeping a job, especially paying for school on a weekly basis. I knew that. …everything was on me." [Winter]

Working remained a number one priority for Spring as well.

> "I started my first job at 15 and when she [Mother] realized that I could earn she wanted me to earn more. I ended up stop focusing on school to help make ends meet at home, but it was always my dream to finish school and have a career." [Spring]

Dysfunctional mother-daughter relationships and its influence on views of motherhood

An unanticipated pattern formed when analyzing data for co-occurring experiences with stress over the life course. The presence of tension between participants and their mothers was heavily referenced. This sparked a closer analysis of the code set to trace first the frequency of these events, then the contextual narrative in which they were phrased. Considering the findings in vast studies about the benefit of personal relationships to one's improved health outcomes, it became vital to the data analysis process to trace a timeline of stressful events that involved the participant's self-proclaimed traumatic and stressful periods and that which simultaneously involved an interaction with their mothers. The findings were surprising. The narrative began to take shape around the instances of verbal abuse and neglect and its role in motivating each woman to seek an independent lifestyle and not motherhood. Furthermore, the reasons behind each participant's pursuit of social mobility and improvement was informed and molded by undesirable experiences within the homes, environments which fostered demanding work but not self-care. Instead of having nurturing relationships to offset life's obstacles, the mother-daughter relationship each woman expressed contributed to the pressure each felt well into adulthood. All participants unanimously expressed painful memories of physically or emotionally absent

mothers. Each participant decided to avoid motherhood. When asked how they envisioned their adult lives during adolescents, many blatantly stated their disinterest in ever becoming a mother. "I wouldn't have started one [family]… I didn't want children." [Winter] Instead, they sought to focus on improving their lives through obtaining higher education and lucrative careers.

Despite her mother's pattern of unemployment and need to care for four children, Spring became responsible for the wellbeing of her siblings, both inside the home and even for their performance in school. She mentioned times when her mother would force her to leave the haven of her grandmother's home where she lived primarily, only to go to her mother's home to watch her siblings so that her mother could enjoy a nightlife with her friends. She would bring food home from school or even prepare dinner in her mother's absence who would be away from the home for days at a time without reason. She could not recall ever receiving compassion or affection from her mother.

> "My mother was the opposite she was only concerned with which club was happening and who was throwing the best party. To her I was only a baby sitter. This is where I believe a lot of my insecurities stemmed from and why I struggled with the fundamentals of being an adult." [Spring]

Essentially, she developed a sense of neglect from this experience and there were a lot of stressful times when she did not know what to do or where to turn to. Having to make these types of decisions as a nine-year-old girl is arguably a traumatic experience and it was one that she experienced well into her teens when she first became pregnant. As she got older, she was gradually persuaded by her mother to gain employment and supplement the loss income at the expense of her own education. Spring said:

> "I started my first job at 15 and when she [Mother] realized that I could earn she wanted me to earn more. I ended up stop focusing on school to help make ends meet at home, but it was always my dream to finish school and have a career." [Spring]

Spring began working at a local chain restaurant at the age of fourteen to afford the basic utilities and other necessities for herself, her mother and three siblings. This experience lasted for years and led to her inability to graduate high school with her class and instead work to complete her G.E.D online while also working fulltime.

Further complicating her experience was the verbal abuse she received at the hands of her mother. Being called a "bitch" in fits of rage was not an isolated occurrence and in fact, became an expected reaction in her mother's frustration with her own challenges of living life and caring for a family as a single parent. This came to a head in one example where she recollected one of the most traumatic experiences in her life. The same night that she lost her virginity, she was beaten in the shower by her mother's sister and taken to a police station, where a rape kit was performed despite her disapproval. Although she had consented to have sex with her partner, her mother found it unacceptable that at the age of fifteen she was involved with an eighteen-year-old boy. In time since the incident, she recalls her mother referencing the event occasionally and even calling her a "rape-kit bitch" when she became angry or during an altercation. The mental and emotional strain of this frequent occurrence cannot be measured given the limited resources in the current study but certainly shed light on the factors that motivate a person to go to any lengths to seek education and career growth as an escape from the cohabitation with their mothers and families. Before going forward, it is important to note that towards the end of her interview when she could further elaborate on any topic of her choice, Spring admitted her mother's ongoing struggles with drug and alcohol abuse. However, she did not become aware of the issue until her late teens. It is something that continues to strain the transactions she has with her mother and the stress it yields in their relationship. Their interaction is inevitable. Despite

their history Spring continues to engage with her mother, allowing her to be a grandmother to her current children . She describes the relationship as an uphill battle.

The instance of dysfunctional or otherwise undesirable encounters between mother and daughter was present in the lives of each participant. The common reference was to limited words of affirmation and even less expressions of affection. For Autumn, there was a cultural barrier that prevented my ability to confidently trace certain elements due to her mother's cultural presence in her parenting style. Nonetheless, the basic signs of nurturing were certainly absent. In a heartbreakingly nonchalant tone, Autumn mentioned only being able to remember one time of her mother ever speaking the words "I Love You" to her. Although she did not mention having any horrific interactions, she did reference her mother's emotional absence as having an impact on her own disinterest in becoming a mother. As mentioned earlier, it was her mother who took her to her first OBGYN appointment where her first traumatic event took place. It was also her mother's scolding reaction that intensified her anxiety because of that experience and led her to further jeopardize her health by refraining from having annual exams. Furthermore, she acknowledged how it made her feel to be disregarded and not have the support of her mother as an outlet to relieve stress. The result of her experience influenced her to work hard to complete college and earn a living for herself. The anxiety of her first pap smear was so extreme that it also weighed heavily on her decision to refrain from sexual intercourse well into her adult life. She feared the process of labor and giving birth to the extent that it was mentally debilitating to think about. Throughout her teens and as an adult, she experienced fainting spells and even hyperventilated at the idea of having any form of physical examination in her vaginal area. By her late twenties she had made the decision not to ever become a mother. As life would have it however, she eventually became married, but the anxiety of pregnancy caused her to cope

by putting most of her focus on her job in efforts to "forget about being pregnant for a while" (Autumn).

> "Believe it or not I never aspired to be a wife or mother. I pictured myself to be a grown and sexy person who had a career… I met my husband and I realized like dang I guess I have be a wife and a mother now. It wasn't something I was opposed to, but it just wasn't a goal." [Autumn]

After missing her monthly period, Autumn took a pregnancy test. It was positive. The first person she called was her therapist. Being at work when her miscarriage began was telling of her insistence of working to keep her mind off the fear of being pregnant. The fear however, was exacerbated when she got to the hospital and realized she had to undergo a vaginal exam to ensure that the miscarriage would occur naturally and not have lingering effects on her reproductive system. In the years that past leading up to her second pregnancy of her now eight-year-old son, the anxiety continued to surface and alter her ability to function without medication. Even now when she has to go to the OBGYN, she needs to take a sedative. Although she does not blame her mother for her continued anxiety, she does acknowledge how having her insight may have prevented the traumatizing outcome of her first pap smear. She also mentions how her mother's emotional absence has transferred into her own reactions.

The absence of Winter's mother in her life was a prominent topic in her discussion. She lived with her grandmother primarily and was only acquired by her mother to live in her home as an afterthought. Unlike the other participants however, her absence was physical due to living miles away in a boarding school where she spent nine months out of each year. After spending time in the military, her mother had been remarried by the time she was nine years old and sent for her to fulfill her ideal of nuclear family. As mentioned earlier, she was only in this home for a few months however before being sent away to boarding school. This existence continued until she graduated at the age of eighteen. In her development of womanhood, she sought to foremost

empower herself through education. Without the moral or financial support of her mother, Winter recalls being overwhelmed by the tasks necessary for her success. Her resilient dedication to being independent motivated her and thus discouraged her from pursuing motherhood. Winter explained:

> "It was extremely expensive, and I got very little in financial aid. The out of pocket expense was high but luckily…most of it was paid by me through a payment plan. I had to be honest about my finances because I didn't have the amount of money needed to go to there, it was a private school and very expensive but once I got in I just did what I had to do."
> [Winter]

As she continued to share her memories, the tensions between her and her mother were apparent. Again, her story of seeking professional success uncovers a commonly overlooked theme related to the consequence of such process. Leveraging social upward mobility as a means to escape the home life where tensions are high between mothers and daughters seems to indicate a pattern of doing so as a behavior to deal with stress. Most commonly referenced, keeping busy by spending long hours studying to not simply pass but excel in college while financially supporting one's self and or others is something that three of the four participants endured. It wasn't until the life altering event of miscarriage and stillbirth, were they forced to reflect on these and other events that had occurred in their lifetime to make sense of how to move forward. Each participant acknowledged that the lack of maternal support created a huge obstacle in healing from the loss of their child.

4.3 Summary

Overall, despite the inability to conclude with causal factors that measure the extent to which the impact of the stress mentioned played a direct role in the miscarriages and stillbirths these women experienced, it can certainly be a starting point to future discussion about the lives of African American women. Furthermore, the data collected from these interviews show the

importance of understanding life course patterns of African American women, with an intent to explore the weathering process of improving one's socioeconomic status. Their role in the family is the starting point that indicates early experiences which may be unique when compared to women from other ethnicities. Additionally, their role in society compounds their experiences and increases their exposure to chronic stress. These instances of overlapping encounters with stress promotes a narrative that recognizes African American women who have had to consistently make impactful decisions and whose resiliency was a requirement. Their shared experience of pain and strength do not overshadow their disparity in infant mortality but could imply their heightened level of risk. The next chapter will discuss those implications and suggest considerations for future studies.

5 CHAPTER 5: DISCUSSION AND CONSIDERATIONS FOR FUTURE STUDIES

The purpose of this study was to explore the ways in which racial and class-based stress accumulate over the life course, to identify links between negative birth outcomes with African American women with higher levels of education and income. The research questions guiding this study were as follows:

1. How do African American women with higher socioeconomic status conceptualize their levels of stress before and during a pregnancy that ended in miscarriage of stillbirth?
2. What styles of coping do African American women with higher levels of income and education engage in during pregnancy?

Although these questions served as the starting point of the study, ultimately the voice of the participants guided the interview discussion. There were many insights discussed that had not been considered regarding trauma and stress accumulation during the process of social mobility. As a researcher, this piqued my own interest into investigating the factors of stress contributing to their experiences and the long-term impact they faced as a result. It was presumed that the outcome would highlight links between their efforts towards coping when presented with this form of stress and that which resurfaced during their pregnancy. Ultimately, there were similarities between the behaviors chosen to cope with stress. The participants expressed a tendency to cope by seeking work outside the home to avoid confronting the stress they acquired from the dysfunctional relationships with their mothers. This was also the reaction when presented with stress during their pregnancies. While the body is at risk for health issues when put under immense amounts of stress from one's environment, this must be exasperated when the body is simultaneously working to grow and nurture life inside the womb. What then are those situations that create the "keep busy" mentality and why is this the sought after means by which

these women have chosen to cope? In the case of the women in this study, the answer is not a depiction of their immorality but a reflection of their resilience. The outcome of this methodology yielded direct connections between codes related to increased stress due to the household environment and codes related to increasing one's workload inside and outside the home.

5.1 The Larger Narrative

As with each season, there exists a weathering effect which requires us to undergo a series of adjustments to ensure survival. The collected narrative expressed by participants Autumn, Winter, Spring and Summer highlight the weathering effect of chronic stress or stress accumulated on a consistent basis over the life course (Zilioli, 2017). After analyzing their experiences, it is asserted that the physiological impact of stress involves wear and tear on the mind and body. If never addressed or affectively managed, the result can be inevitably fatal (Robinnette, 2016). Based on the data collected, constant unavoidable instances of stress related to completing basic tasks like working outside the home and caring for others occurs at earlier stages in life than presumed by modern discourse. The collective voices of these women uncover an important aspect regarding the experiences of African American women that is widely overlooked in research on this topic. The resiliency to encounter life altering trauma like pregnancy loss or domestic violence and prevail in a society that offers no additional privilege is no small feat and should certainly supersede narratives of African American women that suggest otherwise.

For decades, the discourse of infant mortality has suggested that the morality of African American women with lower levels of education and income is the cause of their poor health outcomes (Washington, 2006). Topics related to matriarchy and limited access to healthcare

dominate the field of medicine and public health yet the gap in infant mortality continues to grow for African American women whose climb up the social ladder is hardly investigated to consider the impact of hardships along the way. By leveraging both quantitative and qualitative studies whose findings show links between perceived stress, bodily disfunction and negative health and birth outcomes, the health of African American women with higher levels of SES may benefit closing the disparity highlighted in this research effort. Although the assumption that improvements in social status directly leads to improved health outcomes is true for some Americans, it is hardly ever the case for African American women, especially in their ascent up the social ladder (Farris, 2014).

5.2 Applications across similar research

Authors conducting research to conceptualize the shared experiences of African American women, have increasingly highlighted the importance of further studies to position the voices of these women at the forefront of the agenda. Additionally, there have been some significant insights that have arisen from both quantitative and qualitative studies hoping to uncover practical applications to decrease the infant mortality disparity overall. Kyrah Brown's qualitative study published within the last five years was one that leveraged a phenomenological approach and found significant links between early life experiences and infant death for African American women (Brown, 2016). The life course perspective was used to trace a timeline of self-described experiences with adversity. The findings indicate that African American women experience adversity at high frequencies, arguably higher than women of other ethnicities in the United States (Brown, 2016). While her study probed the participants to disclose important memories of their lives over the life course, the socioeconomic status and mobilization therein was not addressed. While the results contribute to the public health field of study by raising

awareness of the growing threat infant mortality has for African American women, there is not a robust discussion recognizing their experiences related to the mobility of their social class status. There is a wealth of information that could be gathered to identify the unique experiences Black women encounter related to stress and results in their poorer health outcomes.

In May of 2017, Dr. Joedreka S. Brown Speights and colleagues presented research findings aimed at identifying practical applications towards eliminating the state to state racial gap in infant mortality (Brown-Speights, 2017). Interestingly, the study found that some states experienced drastic decreases in the IMR for African American women while others experienced little to no variation. Research efforts like these present the field of African American studies and Public Health with impactful data that can encourage the decision making of policy makers who provide the funding needed to expand the reach and scope of the data collected. Furthermore, more funding means an increased sample population and thus greater generalizability. Ultimately, these efforts help promote the proposed outcome for African American women to receive customized prenatal care due to their heightened risk due to over exposure to stress and adversity. Additionally, these studies further the narrative that infant mortality and poor birth outcomes are not the result of bad nor high risk behaviors and markers of our genealogy as African American women. Instead the disparity in infant mortality in the United States is a public health crisis, one that will require a joint effort by both researchers and medical practitioners to become keen to the frequency of stress encounters, compounded adversities and the physiological impact this has on the mind and body of African American women (Farris, 2014).

5.3 Sojourner Syndrome: The missing link in research methodology for studies about the lived experience of African American women

In the process of conducting external research to examine the depth of literature on the topic of infant mortality, there were many references of the lived experiences of African American women. Few however, focused their efforts on the complexity that stress adds to the conversation about poor health and birth outcomes. Furthermore, especially within the last 30 years when stress is considered in research it is often presumed to be situational and rarely investigated for its chronic presence (Sterling, 1988). As researchers, we may be making a critical oversight. This was one of the initial problems that sparked an interest for conducting the proposed study. It became crucial to follow the data while taking a closer look at those specific experiences that nuance the discussion where African American women's health is involved. In order to do so, requires the application of a theory that could frame the narrative around health outcomes in a meaningful way that does not accuse African American women of inherent carelessness. Above all, the most instrumental tool in the methodology and design of this study was the use of the Sojourner Syndrome as a theoretical framework for adding context to the experience of being an African American woman in the United States. The Sojourner Syndrome explains how African American women privilege the needs of others over their own health (Davis, 2014). For the purpose of this study, it was most useful in promoting a narrative that highlights the resiliency of African American women and simultaneously discourages the misnomer that infant mortality is the cause of low income and poor education. Even now, low socioeconomic status is the most commonly referenced subject in discussions around the disparity of infant mortality within the African American community (Lundquist, 2014). The current study found that narrative to be inadequate and misleading considering the fact that risks

for negative birth outcomes increase as socio economic status increases (Dominguez, 2011). Accordingly, the solution was to formulate a narrative using the voice of each participant to discourage further reference of current discourse regarding African American women with low to poor income and education as the image of infant mortality.

By leveraging the theoretical frame work put forth by Dr. Leith Mullings and furthered by Dr. Sarita Davis, the sojourner syndrome provides the context that gives respect *to* the lived experience and draws *from* those experiences, allowing for the breadth and depth of African American women to be fully and respectfully explored (Davis, 2014). Moreover, the applicable nature of this theory including caring for others and over exerting efforts to place others before one's self is an incredibly valiant characteristic that also often goes unrecognized (Mullings, 2005).

The current study was substantially supported by the sojourner's syndrome in the construction of interview questions which allowed for a discussion predominantly driven by the voice of the participant. More importantly, this theory creates a space for the participant's voice to flow effortlessly and encourages their disclosure of emotions and feelings that they might otherwise overlook as proven in other studies that choose this as a framework (Davis, 2014). The data is more robust as well due to the theory's ability to address the superficial layers of experience first, naturally progressing into those thoughts and memories that are more challenging to provoke and less explored. The conversations become situated to consider the uniqueness of the various experiences and the interview sessions become more therapeutic for the participant. Since African American women are usually spoken for, this theory promotes the voices of the participants and places them at the forefront of the discussion (Giscombe, 2011). Moreover, the narrative is defined by the participant's own experience and highlights the

frequency of similar experiences across the sample. As realized in the process of data analysis, this theory adequately magnifies the many points at which one's ethnicity, gender and class intersect (Mullings, 2005).

5.4 Suggestions for future research

Considering that the shared experiences of the participants in this study are so closely related regarding traumatic events and strained maternal relationships beginning in childhood, more research must be conducted to measure the physiological impact of these encounters on the body. The accumulation and management of stress is an involuntary function of the body controlled by the central nervous system (Robinnette, 2016). This system manages the flow of blood to all internal organs along with the signals that inform the brain on how to respond to various stimuli and communicate with all other organs in the body (Sterling, 1988). As mentioned earlier, research related to the release of stress hormones and the balancing required to function healthily (allostasis), prove that the body must have a period of rest to achieve this (Zilioli, 2016). Constant fluctuations in stress and the active coping used to address it leads to one's body developing an allostatic load (Zilioli, 2016). What this means is that much like any device that relies on battery power, that battery must be charged in order for it to function properly. Our bodies naturally attempt to maximize our internal "battery" so that we are able to deal with stressful situations in a way that does not completely deplete our energy for each encounter with stress. In regard to reproductive health, with the uterus being the most essential organ in the process of pregnancy, we must strive to identify the impact of chronic stress on the female ability to give birth to healthy babies with long-term positive outcomes (Brown, 2016).

Resiliency cannot be overlooked. While survival requires making adjustments to sustain life's series of adversities, researchers must consider both the benefits and disadvantages to

persevering in modern U.S. societies (Davis, 2014). As mentioned in other research studies leveraging the sojourner syndrome, the experience of being both Black and a woman often gets over looked in discussions about racial inequality and environmental stress. Despite African American women's contribution towards the US economy across the class statuses (working class to white collar) not often enough are their experiences considered. Many assumptions can be made about the coping styles chosen to deal with disadvantageous circumstances, but we must also consider the unique forms of stress African American women encounter and the potential over exertion of energy or "high effort" styles of coping conducted with good intentions to better one's social standing and improve one's livelihood (Brown, 2016).

5.5 Gaps in this study

While a purposive sampling method was used in this study for convenience due to time constraints, research of this topic would benefit greatly from snowball sampling. The potential magnitude of sample size focusing on African American women with increased levels of income and education would allow for a more meaningful comparison to their disparity in infant mortality. Also, doing this would certainly increase the generalizability of the results to represent larger populations within the U.S and support current initiatives for policy change and public health awareness (Farris, 2014). Additionally, identifying practical applications of healthy coping mechanisms based on the stories collected from interview sessions may provide more women with an opportunity to focus on self-care as they mobilize towards better careers, education and social status.

Future studies whose interview questions are designed to magnify the consciousness of the participant's own resilience in overcoming adversity can also be beneficial in gathering more robust data. Pinpointing as many events and experiences that involve the creation or

intensification of stress is incredibly important to the mobility of the results towards raising awareness and promoting better birth outcomes. In such studies, the participant's voice should remain central to the narrative proposed (Teti, 2016). Additionally, the narrative should ascend with a clear agenda of deconstructing misnomers and misinformation about African American women and their morality (Washington, 2005).

The experiences shared by participants can be therapeutic to other African American women in particular, as a guide through challenging experiences. The potential outcome of pregnancy loss should not continue to be a consequence of being an African American woman in today's society (Lundquist, 2014). However, our current increased risk for negative birth outcomes should indicate to the larger medical and public health industries the need for more expansive and or customized prenatal care. Furthermore, the frequency of these shared experiences may further support the validity of results in qualitative studies that seek to connect the historical context of the lived experience of African American women and the disparate rate of infant mortality in our community (Brown, 2016).

An added measure to improve the data collected in future studies would be to consider each participant's experience with stress as it relates to racism, their SES or gender over the life course. To conduct a more complete analysis, it may benefit the study to provide each participant with a standard time line template to mark the general year and or age of each self-explained stressful event that is disclosed. This may be a helpful tool to help in the memory process on follow up interviews and to assist in keeping each person's self-reflection consistent with the topic of the study.

5.6 Meaningful insights

The unexpected topic of mother-daughter relationships arose in each participant's account of early experiences with stress and trauma. These are relationships that hardly receive attention in discourses related to familial and interpersonal relationships as paternal relationships tend to dominate the cause for inquisition. The benefit that has come from recent studies however are the practical applications that suggest obtainable solutions to strengthen relationships (Jackson, 2012). Numerous studies that investigate African American reproductive health control for socioeconomic status to observe the impact of environmental factors (Brown, 2016). The findings in these studies have implications for comparison for the negative impact in health and birth outcomes expressed in the accounts of the women who participated in the current study (Brown, 2016). The relationships developed between mothers and daughters carried more weight in one's absent desire to become a mother than what was expected when the original interview questions were written. What is known however, is that unsupportive familial and interpersonal relationships are detrimental to one's overall health (Jackson, 2012). These relationships may be indicators of negative verbal and inferred messaging regarding health and could potentially explain more about the female African American experience with birth outcomes in the United States.

5.7 Conclusion

Certainly, positive birth outcomes can be achieved for African American women who manage to obtain success despite constant encounters with adversity. This study suggests that in doing so will require both self-care and the awareness of medical professionals whose approach in their practice must involve sensitivity to recognize the prevalence of African American patients with a history of heightened times of stress, anxiety or other traumatic events throughout

the life course. While taking a relaxing vacation to an uncharted island or at the least a routine trip to the spa sounds peaceful and ideal, climbing the social ladder to accomplish educational success in college or professional success on a job do not directly offer these privileges. Instead African American women inadvertently begin to care for others and themselves, instinctively taking on a role of independence and responsibility while simultaneously learning how to cope by staying busy. Although there are outlets for stress management such as psychological or clinical therapy and self-help books, policies and grants must be lobbied for, to establish accessible programs that are flexible enough to accommodate African American women who meet these profiles and are subsequently at risk for infant mortality. An ultimate goal would be for African American women to receive customized prenatal care typically provided to those mothers deemed as "high risk" due to pre-existing health abnormalities, beginning with their first pregnancy. As it stands, without a pre-existing health condition, women must suffer the loss of a pregnancy to miscarriage or stillbirth before receiving care from maternal fetal specialists in subsequent pregnancies in order for the pregnancy to be considered "high risk." From my own experience with maternal fetal specialists, having weekly physicals and checkups certainly help to subside any superficial anxiety. Knowing that there were a team of doctors who were all informed of my previous experience with stress and loss created hope which helped maintain a positive outlook on the success of my pregnancy and the health of my unborn child.

The findings in this study in addition to the voices shared, support the need to elevate the care that African American women receive from healthcare providers throughout their lives to account for the stress that accumulates to commiserate their increases in education and income. It should not be assumed that African American women who are career driven or increasingly educated subsequently fair better regarding health merely because of their increased access to

healthcare (Farris, 2014). In fact, this level of thinking perpetuates stereotypes that began at the creation of medical practices in the US on enslaved African American women who were presumed to be unaffected by pain (Washington, 2006). Public health officials and sociologists within the field of African American studies must continue to collaborate to eliminate the disparity in infant mortality and eventually improve the birth outcomes for all women (Farris, 2014). The topic of Allostatic load monitoring is a fascinating discovery and may prove to be significantly successful during routine/preventative screenings especially if introduced during reproductive years when women indicate an interest to become pregnant while maintaining a fully active lifestyle (Robinette, 2016). With continued research, one-day African American women can achieve significant increases in the rate of positive birth outcomes as opposed to the current consequence of infant mortality related to their resilient spirits and social mobility in the Unites States.

REFERENCES

1. Alio, A. P., Mbah, A. K., Kornosky, J. L., Washington, D., Marty, P. J., & Salihu, H. M. (2011). Assessing the impact of paternal involvement on racial/ethnic disparities in infant mortality rates. Journal of Community Health: The Publication For Health Promotion and Disease Prevention, 36(1), 63-68. doi:10.1007/s10900-010-9280-3
2. American Psychological Association,Task Force on Socioeconomic Status. (2007). Report of the APA Task Force on Socioeconomic Status. Washington, DC: American Psychological Association.
3. Association of State and Territorial Health Officials. "Health Equity Policy Statement." 2012. Available at http://www.astho.org/Research.aspx. Accessed 6/1/2016.
4. Brown, K. K., Lewis, R. K., Baumgartner, E., Schunn, C., Maryman, J., & LoCurto, J. (2016). Exploring the Experience of Life Stress Among Black Women with a History of Fetal or Infant Death: a Phenomenological Study. Journal Of Racial And Ethnic Health Disparities.
5. Brown Speights, Joedrecka S. (2017). State-Level Progress in Reducing the Black–White Infant Mortality Gap, United States, 1999–2013. *American Journal of Public Health*. doi: 10.2105/AJPH.2017.303689.
6. Carty, D.C. (2015). Adverse Birth Outcomes In U.S.- And Foreign-Born Black Women: A Conceptual And Empirical Analysis. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.918.3519
7. Centers for Disease Control and Prevention. (2013). *The CDC guide to strategies to increase physical activity in the community*. Retrieved from http://www.cdc.gov/obesity/downloads/PA_2011_WEB.pdf
8. Creswell, J.W. (2007). Qualitative inquiry and research design: Choosing among Five Approaches (2nd Ed.). Thousand Oaks, CA: Sage.
9. Deniz, C., & Ayaz, S. (2014). Factors causing stress in women with babies 0-3 months old and their coping styles. *Journal Of Psychiatric & Mental Health Nursing*, *21*(7), 587-593. doi:10.1111/jpm.12119
10. Davis, S. (2014). The Sojourner Syndrome: An Interpretive Framework for Understanding Poor Black Women's HIV Risk. *Transforming Anthropology*, *22*(2), 121-134. doi:10.1111/traa.12034

11. Dominguez, T. P. (2011). Adverse Birth Outcomes in African American Women: The Social Context of Persistent Reproductive Disadvantage. *Social Work In Public Health*, *26*(1), 3-16. doi:10.1080/10911350902986880

12. Farris, Kimberly. (2014). Healthy Life, Healthy Baby, Healthy Me: Promoting Positive Reproductive Health Outcomes: A Communication Campaign Plan to Combat Adverse Birth Outcomes among Higher Socioeconomic Status African American Women. Rollins School of Public Health, Career Masters of Public Health (Prevention Science) http://pid.emory.edu/ark:/25593/gjqzm

13. Giscombé, C. L., & Lobel, M. (2005). Explaining Disproportionately High Rates of Adverse Birth Outcomes among African Americans: The Impact of Stress, Racism, and Related Factors in Pregnancy. Psychological Bulletin, 131(5), 662-683. doi:10.1037/0033-2909.131.5.662

14. Graham, J., Lei, Z., & Schwalberg, R. (2007). Association of Maternal Chronic Disease and Negative Birth Outcomes in a Non-Hispanic Black-White Mississippi Birth Cohort. Public Health Nursing, 24(4), 311-317. doi:10.1111/j.1525-1446.2007.00639.x

15. Guardino, C. M., Schetter, C. D., Bower, J. E., Lu, M. C., & Smalley, S. L. (2014). Randomised controlled pilot trial of mindfulness training for stress reduction during pregnancy. Psychology & Health, 29(3), 334-349. doi:10.1080/08870446.2013.852670

16. Hessol, N. A., & Fuentes-Afflick, E. (2005). Ethnic Differences in Neonatal and Post-neonatal Mortality. *Pediatrics*, *115*(1), e44-e51.

17. He, X., Akil, L., Aker, W. G., Hwang, H., & Ahmad, H. A. (2015). Trends in infant mortality in United States: a brief study of the Southeastern states from 2005-2009. International Journal Of Environmental Research And Public Health, 12(5), 4908-4920. doi:10.3390/ijerph120504908

18. Hogue, C.J, & Bremner, J.D (2005). Stress model for research into preterm delivery among Black women. American Journal of Obstetrics and Gynecology, 192, S47-55.

19. Kitsantas, P., & Gaffney, K. F. (2010). Racial/ethnic disparities in infant mortality. Journal Of Perinatal Medicine, 38(1), 87-94. doi:10.1515/JPM.2010.014

20. Jackson, F. M., Rowley, D. L., & Owens, T. C. (2012). Contextualized stress, global stress, and depression in well-educated pregnant, African American women.Women's Health Issues, 22(3), e329 – e336.

21. Lundquist, J., Elo, I., Barfield, W., & Xu, Z. (2014). Racial disparities in US infant birth outcomes: A protective effect of military affiliation? Race and Social Problems, 6(2), 161-180. doi:10.1007/s12552-013-9108-8

22. Maltz, M. D., & Mullany, J. M. (2000). Visualizing Lives: New Pathways for Analyzing Life Course Trajectories. Journal of Quantitative Criminology, (2). 255.

23. Masho, S. W., Price, S. K., Kinser, P. A., & Jallo, N. (2015). Racial Disparities in the Association Between Stress and Preterm Birth. *Journal Of Health Disparities Research & Practice*, *8*(4), 80-92.

24. Mullings, L. (2005). Resistance and resilience: The Sojourner Syndrome and the social context of reproduction in central Harlem. *Transforming Anthropology*, *13*(2), 79.

25. Pieterse, A. L., Carter, R. T., & Ray, K. V. (2013). Racism-related stress, general life stress, and psychological functioning among Black American women. *Journal of Multicultural Counseling and Development*, *41*(1), 36-46. doi:10.1002/j.2161-1912.2013.00025.x

26. Prather, Cynthia, Fuller Taleria R., Marshall Khiya J., and Jeffries William L. IV. The Impact of Racism on the Sexual and Reproductive Health of African American Women. Journal of Women's Health. July 2016, 25(7): 664-671. doi:10.1089/jwh.2015.5637.

27. Reddie, A. (2010). Black Theology, Slavery and Contemporary Christianity: 200 Years and No Apology. Farnham, Surrey, England: Routledge.

28. Robinette, J. W., Charles, S. T., Almeida, D. M., & Gruenewald, T. L. (2016). Neighborhood features and physiological risk: An examination of allostatic load. *Health And Place*, *41*110-118. doi:10.1016/j.healthplace.2016.08.003

29. Sterling, P. and J. Eyer. Allostasis (1988). A New Paradigm to Explain Arousal Pathology. In Fisher, S. and J. Reason, eds. Handbook of Life Stress, Cognition and Health. New York, John Wiley & Sons. Chapter 34.

30. Teti, M., Conserve, D., Zhang, N., & Gerkovich, M. (2016). Another Way to Talk: Exploring Photovoice as a Strategy to Support Safe Disclosure Among Men and Women With HIV. *AIDS Education & Prevention*, *28*(1), 43-58 16p. doi:10.1521/aeap.2016.28.1.43

31. U.S. Census Bureau, Population Division. (2016). Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015

32. Washington, H. A. (2006). Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present. New York: Doubleday.

33. Williams, D. R., & Wyatt, R. (2015). Racial Bias in Health Care and Health: Challenges and Opportunities. *JAMA: Journal Of The American Medical Association*, *314*(6), 555-556 2p. doi:10.1001/jama.2015.9260

34. Zilioli, S., Imami, L., Ong, A. D., Lumley, M. A., & Gruenewald, T. (2017). Discrimination and anger control as pathways linking socioeconomic disadvantage to allostatic load in midlife. *Journal Of Psychosomatic Research*, *103*83-90. doi:10.1016/j.jpsychores.2017.10.002

APPENDICES

Appendix A: Interview Questions

1. How would you describe your earliest memories as a child?
2. How would you describe your role in your immediate family within your household?
3. What does racism mean to you?
4. Describe your most vivid memories with any encounter with racism.
5. How would you describe your views toward motherhood during adolescents?
6. What were you told about pregnancy and child birth before becoming pregnant?
7. Tell me about the process you experienced while achieving your undergraduate degree.
8. Tell me about your first work experience.
9. How would you describe your experience with discrimination?
10. Have you ever been discriminated against on a job, in a class, in a medical office or any other social setting? If so, what was your experience like?
11. Tell me about how you manage stress.
12. How do you determine if you are feeling stressed?
13. How would you describe your level of stress during the pregnancy that ended in (miscarriage/ stillbirth)?
14. How would you describe your coping choices during pregnancy?
15. How would you describe your role in your immediate family during your pregnancy that ended?
16. How do you define trauma? What would you deem to be a traumatic experience?
17. Tell me about how stress feels to you.

18. How would you describe your level of self-consciousness to your body's reaction to stress?

Appendix B:

1. What is your age?
   - ○ 19 AND UNDER
   - ○ 20-24
   - ○ 25-29
   - ○ 30-34

2. What is your education level
   - ○ ELEMENTARY SCHOOL GRADUATE
   - ○ HIGHSCHOOL DIPLOMA
   - ○ SOME COLLEGE
   - ○ ASSOCIATES DEGREE
   - ○ BACHELORS DEGREE
   - ○ MASTERS DEGREE OR HIGHER

3. What is your annual household income?
   - ○ $10,000-$30,000
   - ○ $31,000-$50,000
   - ○ $51,000-$75,000
   - ○ $75,000 AND ABOVE

4. Age at first delivery
   - ○ 19 AND UNDER
   - ○ 20-24
   - ○ 25-29
   - ○ 30-34

5. Are you currently pregnant?
   - ○ YES
   - ○ NO

6. Were each of your pregnancies planned?
   - ○ YES
   - ○ NO

7. Have you ever experienced a pregnancy loss?
   - ○ YES
   - ○ NO

8. How many pregnancy losses have you experienced?
   - ○ NONE
   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4 OR MORE

9. At what stage was your pregnancy terminated due to still birth/tubal pregnancy/ miscarriage etc.?
   ****If you answered "None" to question #8 please select N/A.**
   - ○ FIRST TIMESTER
   - ○ SECOND TRIMESTER
   - ○ THIRD TRIMESTER
   - ○ POST NATAL UP TO 1YR
   - ○ N/A

10. What is your racial/ethnicity
    - ○ BLACK OR AFRICAN AMERICAN
    - ○ NATIVE AMERICAN/ PACIFIC ISLANDER
    - ○ HISPANIC
    - ○ WHITE
    - ○ ASIAN

11. Have you sought therapy or practiced any form of self-healing to cope since the loss occurred? (Please Circle One)
    a) Yes
    b) No

12. Has your loss taken place prior to 1/1/2015? (Please Circle One)
    a) Yes
    b) No